# Adair Health Care

## Certified Applied Kinesiologist

**Tim Adair DC**
**833 A. Wren Rd**
**Goodlettsville,Tn 37072**
**phone- 615-239-8676**
**Fax-615-239-8325**

### DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC INFORMED CONSENT

**CHIROPRACTIC**
Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, and physical state and spinal conditions. It is important to understand what to expect from Chiropractic health care services.

**ANALYSIS**
A Doctor of Chiropractic conducts a clinical analysis for the purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC) and whether or not the patient is good candidate for osseous manipulation. When such VSS or VSC complexes are found, Chiropractic and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition of if they do not start responding within a reasonable amount of time. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

**POSSIBLE RISK**
Current research indicates that there may be increased risk of Stroke or Cardiovascular Accident with upper cervical Chiropractic manipulation. These same conditions can occur with leaning your head back to have your hair washed at the beauty parlor, star gazing, rotating your head to look in your rearview mirror, rotating your head as a spectator in a live sporting event, extending your head back during an eye or dental exam, etc. The risks of Stroke or Cardiovascular Accident in any of these situations are increased if you re an active smoker, have high cholesterol, have high blood pressure, are on hormones, are overweight, take diet pills or other metabolism enhancing products, or are over the age of 50. These are the same risk factors found within the general population. If you are aware of any health conditions applying to you or within our family history, please inform your Chiropractic Physician.

**INFORMED CONSENT FOR CHIROPRACTIC CARE**
A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare, cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a Chiropractic adjustment or use other ancillary procedures if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make is known or to learn through other health care procedures whatever he/she is suffering from. This could include but is not limited to latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic may make suggestions regarding this. The Doctor of Chiropractic is licensed in a specialized practice and I available to work with other types of providers in your health care regime. Sometimes, the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Similar conditions in different patients may respond differently to the same Chiropractic care.

**TO THE PATIENT**
Please discuss any questions or problems with the Doctor before signing this statement of policy.
I have read and understand the foregoing.

Date:_____ Signature:_____

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## OFFICE POLICY FOR PAYMENT OF SERVICES

Payment is requested at time of services. If you do not have insurance coverage, you will be responsible for keeping your account current at all times. As a courtesy to you, we will be happy to file your claims, providing your insurance company covers chiropractic care. If your insurance company pays only a portion of your balance, the remaining balance (coinsurance) will be your responsibility and must be paid in full at time of service.

If we do not receive a response from the insurance company within 45 days, we will generate an "insurance tracer" requesting payment and or status regarding the claim. This generally prompts a response. However, if after 90 days we have not received proper notification or justification from your insurance company, we will the change your account status to CASH and you will be responsible for the balance at that time. You will also be responsible for filing your insurance at that point. We will provide you with necessary receipts to assist you with your proper filing of claims. This method assures payment in a timely manner. The insurance company vs. patient is much more reliable than an insurance company vs. doctor. If at any time your insurance status changes whether it is a new insurance card or different policy or coverage dropped, please advise us.

We offer services that some insurance companies do not coverage, therefore it is the patient who will be responsible for those charges. Please ask at the front desk if you have any questions regarding this.

It is our goal to give a high standard of care and timely payment are the best way for us to do so.

PATIENTS SIGNATURE OF AGREEMENT:

NAME: _____

DATE:_____

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## NEW OFFICE POLICY REGARDING MISSED OR CANCELLED APPOINTMENTS

Beginning 9-26-05 our office will charge a $25.00 fee for patients who do not give a 24-hour notice when they need to cancel or reschedule an appointment. This policy will also be implemented for those patients who do not show up for an appointment at all. If you arrive to an appointment more than **15 minutes** late, it will be up to our office staff as to whether or not you can be worked into our schedule otherwise we will have to reschedule you for another day. If you have any questions regarding this new office policy and procedure, please feel free to contact our office administrator. Thank you for your cooperation in handling of this matter.

_____ _____

PRINTED PATIENT NAME DATE

_____

PATIENT SIGNATURE

_____

OFFICE PERSONNEL INITALS

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### CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Adair Health Care

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use of disclose our health care information.

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to anther party if they are potentially responsible for the payment of your services
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing, when you come in for treatment or by mail. Please feel free call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures
You have the right to request that we do not disclose your health information to specific individuals, companies or organization. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. We do not send your information out to third parties other than your specific insurance company without another written, signed consent form from you.

Your right to revoke your authorization
You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ _____
Printed Name Authorized Provider Representative

_____ _____
Signature Date

# WELCOME

## Patient Information

Date: _____

SS#: _____

Name: _____

Address:_____

City: _____

State:_____ Zip Code:_____

Sex: Male :____ Female:____

Date of Birth: _____

Marital Status: Single ___ Married ___ Minor ____
Divorced ____ Widowed____ Other: ____

Occupation: _____

Employer:_____

Employer Phone: _____

Spouse's Name: _____

Spouse's DOB;_____

Spouse's SS # _____

Who May we Thank for Referring You?
_____

## Insurance Information

Who is responsible for this account? _____

Relationship to patient? _____

Insurance Co. _____

Subscribers Name: _____

Subscribers DOB: _____ SS# _____

Relationship to Patient: _____

**Assignment and Release**

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company

Dr. _____ all insurance benefits, if any, otherwise Payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature for all insurance submissions.
the above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature: _____ Date:_____

## Contact Information

**Home:** (___)_____ **Cell:** (___)_____ **Work:** (___)_____**E-mail:**_____

**IN CASE OF AN EMERGENCY**

Please contact:

Name: _____

Relationship: _____

Home: (___)_____ Cell: (___)_____ Work: (___)_____.

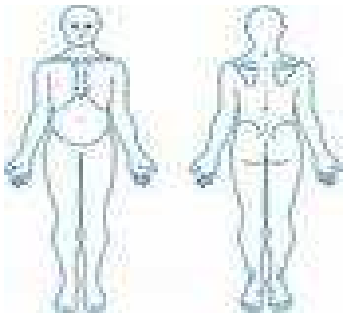
## PATIENT CONDITION

Reason for visit?_____

When did symptoms appear?_____

Is condition getting worse? ___yes ____no

Rate the severity of your pain on a scale from 1(least pain) to 10 (severe pain) _____



Mark on the image above where you continue to have pain, numbness or tingling.

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling
☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities and movements that are painful to preform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

**Health History**

What treatment have you already received for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic
☐ None ☐ Other :_____

Name and phone number of other doctors who have treated this condition? _____

Date of Last: Physical Exam _____ Spinal X-ray:_____ Blood Test: _____ Spinal Exam: _____
Chest X-ray _____ Urine Test :_____ Dental X-ray: _____ MRI, CT, Bone Scan:_____

Place a mark on YES or NO to indicate if you have had any of the following:

AIDS/ HIV ☐ Yes ☐ No
Alchoholism ☐ Yes ☐ No
Allergy Shots ☐ Yes ☐ No
Anemia ☐ Yes ☐ No
Anorexia ☐ Yes ☐ No
Appendicitis ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Bleeding disorders ☐ Yes ☐ No
Breast Lumps ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No
Bulimia ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No
Chicken Pox ☐ Yes ☐ No
Chemical Dependency ☐ Yes ☐ No

Emphysema ☐ Yes ☐ No
Epilepsy ☐ Yes ☐ No
Fractures ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Goiter ☐ Yes ☐ No
Gonorrhea ☐ Yes ☐ No
Gout ☐ Yes ☐ No
Heart Disease ☐ Yes ☐ No
Hernia ☐ Yes ☐ No
Herniated Disk ☐ Yes ☐ No
Herpes ☐ Yes ☐ No
High Cholesterol ☐ Yes ☐ No
Kidney Disease ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No
Migraines ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No

Miscarriage ☐ Yes ☐ No
Mononucleosis ☐ Yes ☐ No
Multiple Sclerosis ☐ Yes ☐ No
Mumps ☐ Yes ☐ No
Osteoporosis ☐ Yes ☐ No
Pacemaker ☐ Yes ☐ No
Parkinson's ☐ Yes ☐ No
Pinched Nerve ☐ Yes ☐ No
Pneumonia ☐ Yes ☐ No
Polio ☐ Yes ☐ No
Prostate Problems ☐ Yes ☐ No
Prosthesis ☐ Yes ☐ No
Psychiatric Care ☐ Yes ☐ No
Rheumatoid Arthritis ☐ Yes ☐ No
Rheumatic Fever: ☐ Yes ☐ No

Scarlet Fever ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Suicide Attempt ☐ Yes ☐ No
Thyroid Problems ☐ Yes ☐ No
Tonsillitis ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Tumors, Growths ☐ Yes ☐ No
Typhoid Fever ☐ Yes ☐ No
Ulcers ☐ Yes ☐ No
Vaginal Infections ☐ Yes ☐ No
Venereal Disease ☐ Yes ☐ No
Whooping Cough ☐ Yes ☐ No
Other :_____
_____
_____

**EXERCISE**
☐ None
☐ Moderate
☐ Daily
☐ Heavy

**WORK ACTIVITY**
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

**HABITS**
☐ Smoking
☐ Alcohol
☐ Coffee/ Caffeine
☐ High Stress Level

Packs/Day_____
Drinks/Week_____
Cups/Day_____
Reason_____

Are you pregnant? ☐ Yes ☐ No Due Date: _____

Please list any injuries or surgeries you have had.(broken bones, head injuries, falls etc.) _____
_____
_____

Medications_____
_____
_____

Allergies :_____
_____
_____

Vitamins/Herbs:_____
_____
_____